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George E. Dix

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DIFFERENTIAL PROCESSING OF ABNORMAL SEX OFFENDERS: UTILIZATION OF CALIFORNIA'S MENTALLY DISORDERED SEX OFFENDER PROGRAM*

GEORGE E. DIX**

Programs for the differential processing of persons convicted of a criminal offense and found—because of psychological abnormality—to present an unusually high danger of commission of future sex offenses[1] have received adverse publicity. The conventional wisdom is that such programs were developed under political and emotional pressure and without adequate consideration.[2] Further, it is often asserted that they are based upon the questionable or erroneous assumptions that the behavior of sex offenders is more predictable and amenable to "treatment" than that of other offenders. Finally, it is often charged that such programs serve to prolong the confinement that persons committing relatively minor sex offenses are forced to endure without any justification for such increased severity.[3]

Nevertheless, sex offender programs have generally survived legal attacks upon their validity,[4] although the Supreme Court recently indicated that the actual operation of these programs could present substantial constitutional claims.[5] Resolution of these constitutional issues, as well as determination of the general acceptability of sex offender programs, requires extensive information concerning the administration of the programs. This article evaluates several aspects of the most extensively utilized program in the United States, the California Mentally Disordered Sex Offender program.[6]

THE CALIFORNIA PROGRAM: AN OVERVIEW AND IDENTIFICATION OF BASIC CONCERNS

Under the California program, an offender convicted of any offense may, as an alternative to sentencing under the applicable penal code provision, be committed to the Department of Health for an indefinite period if he is determined to be a "mentally disordered sex offender" ("MDSO"). An MDSO is defined as

> any person who by reason of mental defect, disease, or disorder, is predisposed to the commission of sexual offenses to such a degree that he is dangerous to the health and safety of others.[7]

If probable cause exists to believe a convicted defendant is an MDSO, an inquiry is conducted. A probation officer's report is compiled and the defendant is examined by two or three court-appointed psychiatrists who file reports with the court. A hearing is then held to determine whether the defendant is an MDSO and, if so, whether he is amenable to treatment. Jury trial is available if the defendant is dissatisfied with the outcome of this hearing.

If it is determined that the defendant is an MDSO, he may be committed to the Department of Health. Prior to 1970, this was a ninety day commitment for observation. Following this observational commitment and receipt of a recommendation from the institution in which the defendant had been confined, a determination was made as to whether the defendant was an MDSO and if so, a decision was made as to indefinite commitment. After the 1970 revision of the statute, however, only a single hearing is held and that addresses the issue of indeterminate commitment.

After indefinite commitment, the defendant may be returned to the court upon the recommendation of the institution, upon the court's own motion, or upon

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** Professor of Law, The University of Texas.

[1] The statutory provisions are fully summarized and compared in THE MENTALLY DISABLED AND THE LAW 366-75 (S. Brakel & R. Rock eds. 1971). Twenty-eight jurisdictions are listed as having some distinctive statutory provision for sexually dangerous persons; two-thirds of these require conviction of a criminal offense as a prerequisite to the proceedings. *Id.* at 343.

[2] *See* Sutherland, *The Sexual Psychopath Laws,* 40 J. CRIM. L.C. & P. S. 543 (1950).

[3] Birnbaum, *Primum Non Nocere: How to Treat the Criminal Psychopath,* 52 A.B.A.J. 69 (1966); Note, *The Plight of the Sexual Psychopath: A Legislative Blunder and Judicial Acquiescence,* 41 NOTRE DAME LAW. 527 (1966).

[4] Minnesota *ex rel.* Pearson v. Probate Court, 309 U.S. 270 (1940).

[5] Humphrey v. Cady, 405 U.S. 504 (1972).

[6] CAL. WELF. & INST'NS CODE § 6300 *et seq.* (1972).

[7] *Id.* § 6300.

demand by the defendant after the first six months, and once every subsequent six months. This return is accompanied by a recommendation. An "A" recommendation is a certification that the defendant has been treated to such an extent that he will not benefit from further care and treatment and that he is not a danger to the health and safety of others. It is, in other words, an assertion of "cure." A "B" recommendation, on the other hand, is a certification that the defendant has not recovered but is not further treatable and remains a danger to the health and safety of others. This is basically a certification of continued dangerousness and of nonamenability to further treatment. If the court review has not been instituted by the institution itself, the recommendation may be that the subject is dangerous and still amenable to the treatment.

If the defendant has been returned with an "A" recommendation, the trial court may sentence the defendant under the penal code provision applicable to the crime of which he was originally convicted or it may impose not less than five years probation. If the defendant is returned with a "B" recommendation, the trial court may sentence him under the applicable penal code provision. In the alternative, the court may—if it specifically determines that he has not recovered and is a danger to the health and safety of others—order the defendant indefinitely committed either to the Department of Health or to the Department of Corrections.

In addition, there is specific authorization for the Department of Health to transfer an MDSO to facilities under the control of the Department of Corrections. Thus a defendant may be detained in a correctional institution under an indefinite commitment either by specific court order, or by virtue of an administrative transfer.

The administrative focus of the MDSO program since 1954 has been Atascadero State Hospital, a maximum security institution located midway between Los Angeles and San Francisco. Almost all persons committed to the Department of Health under the MDSO program are institutionalized there. From 1955 to 1965, approximately 750 MDSO's were under the jurisdiction of the Department of Health at any one time; the total dropped slightly (to 607) in 1970, but by 1973 had increased to 675. Over 90 per cent of these were institutionalized at Atascadero State Hospital. Throughout the period 1955 through 1972, the number of indefinite commitments to Atascadero State Hospital remained remarkably stable at 400 to 425 per year.

The MDSO program gives rise to two main areas of concern. One deals with the adequacy of the definition of MDSO to provide reasonable assurance of even-handed administration. Several portions of the definition raise questions in this regard:

1) the description of the psychological abnormality which must exist: "mental defect, disease, or disorder";
2) the behavior which must be anticipated: acts "dangerous to the health and safety of others"; and
3) the likelihood that such behavior will be performed: a predisposition towards such behavior "to such a degree that [the offender] is dangerous."

These standards are obviously not self-defined. The critical question is whether they have reasonable and well-defined meanings in the actual administration of the program.

The second area of concern is the duration of institutionalization. Since indefinite detention is permitted by the program, the critical question is the extent to which this is implemented.

Administration of the California Program

The MDSO: A Description

To obtain a description of persons found to be MDSO's, random samples of MDSO's committed in 1967, 1972, and 1974 were taken and the files examined. It quickly appeared that the offense for which the person was committed was often an unreliable indicator of the conduct actually involved, so a determination was made as to the most serious form of activity actually committed during the events upon which the criminal conviction was based. Table I contains the results. By far the most common act was child molestation. (This was defined as excluding those forms of conduct, such as forcible rape, that would also come within the other categories.) On the other hand, there was a clear trend towards inclusion of fewer child molestors and more forcible rapists, suggesting an increasing willingness to use the program to deal with violent offenders. But most significant is the infrequent commitment based upon consensual homosexual activity and upon so-called nuisance activity, such as obscene telephone calls and exhibitionism. Clearly, the California program is being used to deal primarily with violent offenders and those involved in sexual activity with children.

Since child molestation was a major target of the program, activities within that category were examined more carefully. Table II breaks down the activity involved for all three samples. Significantly more offenses involved female victims than male victims, although the 1972 and 1974 samples con-

TABLE I

CONDUCT GIVING RISE TO MDSO COMMITMENTS, BY MOST SERIOUS POSSIBLE DESIGNATION

	1967		1972		1974	
	No.	Per cent	No.	Per cent	No.	Per cent
Child Molestation	24	80	34	68	33	66
Forcible Rape	1	3	9	18	11	22
Forcible Sodomy	0	0	1	2	0	0
Forcible Oral Copulation	1	3	0	0	1	2
Incest	1	3	0	0	0	0
"Statutory" Rape	0	0	0	0	0	0
Exhibitionism	2	7	1	2	1	2
"Peeping"	0	0	1	2	0	0
Assault with Sexual Motive	1	3	0	0	0	0
Homicide with Sexual Motive	0	0	0	0	1	2
Theft with Sexual Motive	0	0	0	0	1	2
Obscene Phone Calls	0	0	0	0	1	2
Nonsexual Offense	0	0	4	8	1	2
Totals	30	99	50	100	50	100

TABLE II

CHILD MOLESTING ACTIVITY OF MDSO'S

	1967		1972		1974	
	No.	Per cent	No.	Per cent	No.	Per cent
Sex of Victim						
Male	6	25	14	41	11	33
Female	17	71	19	56	20	61
Both	1	4	1	3	2	6
	24	100	34	100	33	100
Activity Involved						
Physical Touching	11	46	14	41	13	40
Oral-Genital Contact	7	29	9	27	8	24
Penetration (Vaginal or Anal)	6	25	11	32	12	36
	24	100	34	100	33	100
Means of Implementation						
Physical Force Used or Injury Caused	6	25	2	6	8	24
Threats of Force or Injured Used	2	8	2	6	12	36
Neither Force or Threats Used	16	27	30	88	13	40
	24	100	34	100	33	100

tained a larger percentage of male-victim offenses than did the 1967 sample. This may indicate an increased concern regarding sexual behavior with minor males as well as with the traditional female victims.

A substantial percentage of the behavior involved sexual penetration and therefore might reasonably be regarded as relatively serious. Nevertheless, a large percentage of the incidents involved no more than the touching of the victim by the defendant, and only a relatively small percentage involved physical force or threats of such force. It is clear that in large part the program is directed at non-violent persons who engage in relatively innocuous sexually motivated behavior with children.

To what extent were MDSO's "repeaters?" Table III contains an analysis of the prior convictions for sex offenses of those persons in the samples. A substantial—but decreasing—proportion of those committed had no prior *conviction* for a sex offense. But lack of a conviction is a poor indicator of whether the person had engaged in prior activity of

TABLE III

PRIOR CRIMINAL CONVICTIONS FOR SEX OFFENSES

	1967		1972		1974	
	No.	Per cent	No.	Per cent	No.	Per cent
No Prior Convictions	19	63	26	52	24	48
One Prior Conviction	8	27	14	28	18	36
Two Prior Convictions	2	7	7	14	6	12
Three Prior Convictions	0	0	1	2	1	2
Four or More Prior Convictions	1	3	2	4	0	0
Total	30	100	50	100	49*	100

* This information not available for one person in 1974 sample.

this sort. An examination of the file of each person with no prior convictions was made to determine whether there was substantial evidence that the person had engaged in activity constituting a sex offense for which he had not been convicted. An effort was made to determine whether the offender had engaged in previous incidents of prohibited sexual activity. If an offender had engaged in previous acts which were clearly part of the course of conduct upon which his present conviction was based, this was not regarded as a prior incident. Table IV contains the results. Most had, in fact, engaged in prior prohibited activity even though no conviction was obtained. Only about 10 to 15 per cent of MDSO's, then, can be said to have been committed after only one incident of sexual misbehavior.

Determination of MDSO Status: The Clinical Decision

The California program and virtually all other existing programs for special processing of abnormal offenders rely heavily upon recommendations from clinicians such as examining physicians or psychiatrists. To investigate the decisionmaking process of the California program, reports of court-appointed medical examiners concerning patients in the 1967, 1972, and 1974 samples were examined. While these do not reflect the decision or reasoning of the committing court, the tendency of courts to follow the examiner's recommendation justifies relying upon them as the best available evidence concerning the decisionmaking process. Several aspects of this process deserves separate comment.

Data Relied Upon. Perhaps the most significant aspect of the reports and examinations of the appointed physicians was the reliance upon the "social history," often taken from the probation officer's report. There was relatively little reliance upon "clinical observations," that is, characteristics of the defendant or his behavior observed during the examination or interview which might reasonably be expected to have been elicited or noted only by a person with clinical skills.

To the extent that clinical symptoms were observed and reported, they tended to be a lack of guilt concerning the offense (as evidenced by discussion of the offense with no indication of remorse or emotional distress), a failure to acknowledge its seriousness or an unwillingness to assume responsibility for it. Infrequently, evidence of more bizarre symptoms was obtained, such as fantasies involving sexually aggressive acts. But, in general, persons examined evidenced very few of the traditional clinical symptoms associated with serious mental illness. Consequently, the examiner's conclusions were often based primarily upon the defendant's past behavior.

Perhaps because of this reliance on prior conduct the examiners seldom made any effort to address the psychological dynamics of the defendant's activities. If the examinations and reports were intended to enable the court to understand the defendant's behavior in psychological terms, they fell far short of expectations.

Definition of Required Psychological Abnormality. In most cases the examiners were able to diagnose the defendant as having one of the personality disorders included within acceptable diagnostic terminology.[8] A large percentage of the child molesters, for example, were labeled "passive aggressive personalities."[9] There seemed to be general agreement that this sufficed to bring the subject within the statute's requirement of a "mental defect, disease, or disorder." In the occasional troublesome case, how-

[8] AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 41-44 (2d ed. 1968).

[9] *Id.* at 43-44.

TABLE IV

PRIOR INCIDENTS OF CRIMINAL SEXUAL BEHAVIOR ENGAGED IN BY MDSO'S WITH NO PRIOR SEX CRIME CONVICTION

	1967		1972		1974	
	No.	Per cent	No.	Per cent	No.	Per cent
No Incidents	3	16	9	35	6	25
One Incident	2	10	5	19	5	21
Two Incidents	0	0	3	11	0	0
Three Incidents	0	0	0	0	1	4
Four or More Incidents	14	74	9	35	12	50
Totals	19	100	26	100	24	100

ever, the reports revealed a divergence of opinion. Some examiners believed it was necessary to bring the defendant within one of the accepted diagnostic categories to find him an MDSO; others assumed it sufficient that anything "abnormal" could be identified in the subject's behavior or development, whether or not this justified placing one of the traditional labels upon him.

There was substantial confusion among the examiners concerning the impact of intoxicants upon the MDSO determination. Some regarded the fact that the defendant was intoxicated at the time as evidence of psychological abnormality, especially if it was tied to a pattern of alcohol abuse. Others considered this as suggesting that the subject was not an MDSO, either on the ground that intoxicant abuse was not a "mental defect, disease, or disorder" within the meaning of the statute, or because it "explained" the defendant's conduct and therefore excluded psychological abnormality as the cause of the behavior. In view of the substantial proportion of cases in which intoxicants were involved, this confusion was a significant factor.

The "Danger" that the MDSO Must Pose. Generally there was no doubt that the conduct in which it was anticipated the defendant would engage was "dangerous" within any reasonable definition of that term. But in two areas there was substantial question concerning the proper classification of behavior, and neither the statute nor professional standards provided significant assistance in deciding whether the "danger" was sufficient.

One area was exhibitionism. Despite a California decision apparently holding that exhibitionism under any circumstances is "dangerous" within the meaning of the statute,[10] some examiners did not regard it as such. Exhibitionism was regarded by some as evidencing "dangerousness" only because of the examiner's conclusion that the defendant would progress to more "serious" conduct. But others regarded the nuisance and distress aspect of the behavior as sufficient to classify it as "dangerous."

There was similar ambiguity concerning child molesting. In general, examiners were willing to assume that any sexually motivated conduct involving physical touching of a child was "dangerous." But some examiners were unwilling to make such an assumption. This group, however, differed on their definitions of when activity was "dangerous." Some were concerned with the likelihood or psychological harm to the child on the facts of the case before them. Others focused upon the likelihood that future victims would resist and that the defendant would use force to overcome this resistance.

In most cases, then, uncertainty as to what constitutes "dangerous" behavior was not a significant problem. However, in a substantial minority of cases there either was, or reasonably could have been, dispute concerning whether the anticipated activity of the defendant was within the meaning of the statute. Considering the extent to which the MDSO program has focused upon child molesters, the ambiguity concerning the legal status of the activity potentially included within this label constitutes a significant problem.

Likelihood of the "Dangerous" Activity. Examiners' reports uniformly failed to articulate how likely the examiner considered it to be that the subject would engage in the anticipated activity. The reports included statements that the subject is "predisposed" to commit the acts, that he has a "tendency" to commit them, and "if given the opportunity . . . the chances are more rather than less likely that such behavior would reoccur."

Several characteristics appeared to influence the

[10] People v. Stoddard, 227 Cal. App. 2d 40, 38 Cal. Rptr. 407 (1968).

examiners' conclusions concerning the likelihood that feared conduct would be committed. A pattern of past similar behavior was regarded as significant, but—as the discussion above indicates—clearly not essential. If the past conduct of the defendant showed a progression from less serious to more significant behavior (as from exhibitionism to physical contact with children), there appeared a greater willingness to assume both that prohibited conduct would be committed and that it would continue to increase in seriousness. But apart from this, the reports revealed little concerning the bases upon which a conclusion of "predisposition" or "tendency" was reached.

Duration of Hospitalization

To determine the extent to which long-term institutionalization was utilized in practice, the discharge date (or current status) was determined for those MDSO's in the 1967 and 1972 samples. The results are summarized in Table V.

There was no extremely long-term detention in the mental health facility. None of the 1967 commitments were still hospitalized at the time of the study (summer 1974). None were retained longer than two years, and half had been discharged within one year. Comparison of the two samples, however, shows a clear trend towards longer retention. After two years, 30 per cent of the 1972 sample were still hospitalized.

When retention statistics are broken down by recommendation at the time of return to court, it becomes clear that those defendants returned with a "B" recommendation were discharged much sooner than those returned with an "A" recommendation. This reflects a practice of determining quite rapidly which persons will not benefit from the program and returning them to court with a minimum of delay.

MDSO's in the Department of Corrections

To determine whether the authority to place MDSO's in correctional facilities was actually being used to effect long-term detention, information concerning transfer of MDSO's from Atascadero State Hospital to the Department of Corrections was compiled. From 1966 through 1973, an average of twenty-five such transfers occurred yearly. Statistics from the Department of Corrections disclosed that the number of MDSO's under its jurisdiction fluctuated greatly between 1955 to 1973, from a low of sixteen in 1960 to a high of 212 in 1965. On December 31, 1973, fifty-seven MDSO's were under the jurisdiction of the Department of Corrections.

Table VI reports the duration of confinement of MDSO's received by the Department of Corrections in 1966. Comparison with Table V indicates that confinement in corrections tends to be longer than that in the Department of Health. This should not have been unexpected, because placement in corrections represents a decision to abandon treatment efforts in mental health facilities because of difficulty in effectively dealing with the offender. On the other hand, the duration of confinement was not as long as might have been anticipated. About 90 per cent of those in the sample were discharged within four years after being received by corrections.

Comparison with Correctional Processing

The significance of the duration of institutionalization cannot, of course, be evaluated in the abstract. Rather, it must be compared with what would have happened had the persons involved been processed through alternative programs. Such comparison is difficult, because it necessarily requires speculation concerning a hypothetical situation. But some efforts can be made by examining the duration of confinement of persons convicted of sex offenses and sentenced to imprisonment under the applicable penal code provision. Table VII indicates the duration of incarceration of such persons paroled in years corresponding to those used in the discussion above.

Comparison of Table VII with Table V and even Table VI suggests that many offenders who were processed as MDSO's would have been institutionalized significantly longer had they been sentenced to imprisonment under the penal code provision. But such speculation must be made with care. Many of those who were institutionalized as MDSO's might not have been institutionalized at all had the MDSO program not been available. Trial judges who proved susceptible to requests for "therapeutic hospitalization" might have been unwilling to impose what they perceived as more punitive imprisonment.

Recidivism

Probably the most important measure of the effectiveness of a sex offender program is the extent to which it reduces recidivism below what would have otherwise been the case. Yet, this is the most difficult aspect of the programs to measure, and the present study permitted only a limited effort in this direction. Investigations of recidivism often focus upon offenses committed within specified periods following release or discharge of the subjects from the programs under study. While this approach has merit in some contexts, it does not provide an opportunity to

TABLE V

DURATION OF HOSPITALIZATION: PATIENTS COMMITTED IN 1967 AND 1972 (TIME IN MONTHS)

	Total	1 to 4		5 to 8		9 to 12		13 to 16		17 to 20		21 to 24		25 and over		Still Hospitalized	
		No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent
1967 Commitments																	
All Patients	30	0	0	5	17	7	23	12	40	3	10	3	10	0	0	0	0
Patients Returned with "A" Recommendations	23	0	0	0	0	6	26	11	48	3	13	3	13	0	0	0	0
Patients Returned with "B" Recommendations	6	0	0	5	83	0	0	1	17	0	0	0	0	0	0	0	0
Patients Transferred to Corrections	1	0	0	0	0	1	100	0	0	0	0	0	0	0	0	0	0
1972 Commitments																	
All Patients	50	3	6	3	6	6	12	5	20	12	24	6	12	2	4	13	26
Patients Returned with "A" Recommendations	24	0	0	1	4	5	21	5	21	7	29	5	21	1	4	—	—
Patients Returned with "B" Recommendations	10	3	30	2	20	1	10	0	0	3	30	1	10	0	0	—	—
Patients Transferred to Corrections	1	0	0	0	0	0	0	0	0	1	100	0	0	0	0	—	—
Patients Died	1	0	0	0	0	0	0	0	0	1	100	0	0	0	0	—	—

examine and compare the preventive confinement effects of programs which may reduce recidivism—or at least postpone it—by simply retaining the offender in the programs. The need for such comparison is especially great here, because the MDSO program provides an opportunity to identify offenders likely to recidivate but not to benefit from specialized treatment and to channel them into the correctional system for what is probably perceived to be primarily preventive confinement. Continued retention in the MDSO program also has a preventive confinement collateral effect, but the reduced period of institutionalization of persons processed as amenable MDSO's as compared to those sentenced to imprisonment suggests that the preventive confinement impact is less in the MDSO program. In any case, because of a desire to include a comparison of the preventive confinement factor in the examination of the alternative ways of processing sex offenders upon commission of future offenses, this study examined further offenses within a period measured from the offenders' first contact with MDSO program.

TABLE VI

DURATION OF CONFINEMENT (IN MONTHS) OF MDSO'S RECEIVED BY CALIFORNIA DEPARTMENT OF CORRECTIONS IN 1966*

Months of Confinement in Department of Corrections at Time of Discharge	No.	Per cent
1 through 8	8	11.3
9 through 16	24	33.8
17 through 24	15	21.1
25 through 32	5	7.1
33 through 40	2	2.8
41 through 48	7	9.9
49 through 56	3	4.2
57 through 64	4	5.6
65 through 72	2	2.8
73 and over	1**	1.4
	71	100.0

* Does not include 3 MDSO's who died during commitment (after 7, 9, and 51 months of confinement), one who was still confined at the time of the study (after 96 months of confinement) and one for whom accurate information was not available.

** This person was discharged after 77 months of confinement.

Official records of arrests and convictions through summer of 1974 were obtained for those MDSO's in the 1967 sample. This permitted an examination of recidivism during a period of approximately seven years following the offender's initial contact with the sex offender program. Recidivism was calculated by two measurements, arrest and conviction for an offense other than a minor traffic violation. Arrests and convictions were further separated according to whether the offense involved was sexual in nature.

The results (Table VIII) indicate that recidivism is as likely to occur by virtue of a nonsexual offense as by means of a sexually motivated incident. Those persons found to be MDSO's, treated, and returned to court as "cured" showed the highest recidivism rate. But in view of the evidence above that MDSO's spend significantly less time institu-

TABLE VII

TIME SERVED BEFORE PAROLE BY SEX OFFENDERS SENTENCED UNDER PENAL CODE PROVISIONS AND PAROLED IN 1966, 1970, AND 1972

Offense Convicted	Time Served (In Months) Before Parole Release					
	1966		1970		1972	
	Median	Middle 80 Per cent Range	Mediam	Middle 80 Per cent Range	Median	Middle 80 Per cent Range
Forcible Rape	44	19–81	55	30–96	42	22–78
Statutory Rape	*		36	16–80	31	16–67
Oral Sex Perversion	30	12–89	50	26–123	38	21–128
Indecent Exposure (with Prior Conviction)	27	18–58	42	17–50	*	
Nonsex Offenses						
First Degree Robbery	43	35–72	51	33–94	40	24–83
Grand Theft and Embezzlement	22	12–39	27	15–50	25	13–58
All Offenders Paroled	30	12–60	36	18–77	32	14–76

* Less than fifteen offenders in these catagories and statistics not compiled. Source: California Department of Corrections, Research Division.

TABLE VIII

SEVEN YEAR RECIDIVISM OF MDSO'S IN 1967 SAMPLE, BY MANNER OF PROCESSING

Manner of Processing	Total	Non-Recidivists		Recidivists (By Most Serious Incident)							
				Arrest Only				Conviction			
				Nonsex		Sex		Nonsex		Sex	
		No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent
Offenders Committed for Observation Only											
Returned with Recommendation of Finding Not MDSO	7	5	71.4	1	14.3	0	0	0	0	1	14.3
Returned with Recommendation of Finding Nonamenable MDSO	17	12	70.6	2	11.75	0	0	1	5.9	2	11.75
Offenders Indefinitely Committed as Amenable MDSO's											
Returned with Recommendation of Finding No Longer Dangerous	24	14	58.3	2	8.3	1	4.2	3	12.5	4	16.7
Returned with Recommendation of Finding Nonamenable and Dangerous	6	5	83.3	0	0	1	16.7	0	0	0	0

TABLE IX

SEVEN YEAR RECIDIVISM OF NONAMENABLE MDSO'S AND "CURED" MDSO'S IN 1967 SAMPLE

	Total	Non-Recidivists		Recidivists (By Most Serious Incident)							
				Arrest Only				Conviction			
				Nonsex		Sex		Nonsex		Sex	
		No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent
Offenders Found Nonamenable MDSO's	17	12	70.7	2	11.75	0	0	1	5.9	2	11.75
Sentenced to Imprisonment	13	10	76.9	2	15.4	0	0	0	0	1	7.3
Placed on Probation	4	2	50.0	0	0	0	0	1	25.0	1	25.0
Offenders Committed as Amenable MDSO's and Returned with Recommendation of Finding of No Longer Dangerous	24	14	58.3	2	8.3	1	4.2	3	12.5	4	16.7

tionalized than offenders sentenced to imprisonment in the correctional system under the penal code provisions, this higher recidivism rate may be due to the increased opportunity to commit a crime. This is confirmed by Table IX which breaks down the recidivism rate of offenders found nonamenable MDSO's by their disposition and compares this with the recidivism of "cured" MDSO's. Those nonamenable MDSO's who were placed on probation—and thus had even greater an opportunity to commit a further offense during the seven-year period than "cured" MDSO's—showed a higher recidivism rate than other categories. Those sentenced to imprisonment, on the other hand, tended to be "successful" probably in large part because of the lack of opportunity to fail.

These suggestions are based upon examination of small samples, and must be taken with caution. Nevertheless, the followup of this group of offenders suggests that differential processing and "treatment" of "treatable" offenders, when combined with discharge from custody when "cured," may significantly reduce the effect that confinement has upon recidivism. A sex offender program may not be an

effective method of drastically reducing recidivism rates and—to the extent that it reduces the extent of "preventive confinement" that would otherwise be imposed—may actually increase the recidivism of the participants.

Conclusions

Several traditional concerns regarding sex offender programs were proven unfounded by this examination of the California program. On the whole, the availability of the program appeared to ameliorate the harshness of criminal conviction upon a large number of sex offenders. Offenders committed to the program tended to spend significantly less time institutionalized than did similar offenders sentenced to imprisonment. This suggests that many sex offenders spent less time institutionalized under less oppressive circumstances than would have been the case had the program not been in existence, although some offenders may have been committed to the program and thus institutionalized who, in the absence of the program, would not have been sentenced to imprisonment and thus would have escaped institutionalization entirely.[11] Moreover, the program was seldom used to process nuisance offenders, and therefore did not serve to materially disadvantage such persons.

On the other hand, several other concerns appeared to be more well-founded. First, ambiguities in the definitions of the abnormally dangerous sex offender were found to create difficulties in practice. In the hard situations—most importantly the child molesters—there was disagreement and resulting inconsistency concerning what behavior was "dangerous" within the meaning of the definition. This emphasizes the need to specifically define what sorts of behavior with children under what circumstances should subject a person to processing under such programs. In addition, the administrators of the program very rarely addressed the question of the statistical likelihood that anticipated acts would be committed. Given current predictive capacity, such inability to predict conduct is most likely inherent in such programs. But inability to address the issue in day-to-day practice needs to be acknowledged and recognized as a potential deficiency in such programs.

The second major conclusion concerns the ability of clinical mental health personnel to make meaningful contributions to the predictive task. Seldom were psychiatrists or other clinical personnel able to utilize their skills in clinical observation and examination in such a manner as to provide information helpful to courts in making the decision as to the dangerousness of a particular offender. But the utilization of these reports and their clinical-scientific aura appeared to obscure the difficulties of the dangerousness determination. That such difficulties exist cannot be doubted. Kozol et al., in one of the few efforts to test the reliability of clinical predictions concerning future behavior of allegedly sexually dangerous persons, found that 65 per cent of those clinically determined dangerous but released on court order did not commit a subsequent serious assaultive crime.[12] Moreover, the willingness of these investigators to conclude, despite this information, that "dangerousness can be reliably diagnosed"[13] suggests that clinicians such as Kozol and his colleagues may operate with an unacceptable perception of the reliability required for a professional conclusion that a person is dangerous.

The criminal justice system must, of course, continue to attempt to predict dangerousness as long as disposition of offenders is significantly individualized. If reliance upon clinicians' opinions as to dangerousness is to be abandoned, what can be substituted? The primary alternative is to focus upon objective characteristics of offenders that can be readily ascertained and analyzed in a sophisticated manner. Some have urged reliance upon this alternative approach in identifying offenders to be treated as exceptionally dangerous for dispositional purposes. The National Advisory Commission, for example, recommended that the decision as to whether an offender is a "dangerous offender" for sentencing purposes should be based upon the pattern of the offender's past behavior or the circumstances of the offense of which he stands presently convicted rather than upon clinical evaluation.[14] The United States Board

[11] In People v. Feagley, 14 Cal. 3d 338, 535 P.2d 373, 121 Cal. Rptr. 373 (1975) the California Supreme Court, after finding that MDSO's transferred to the Department of Corrections were customarily detained without treatment, held that the statutory scheme authorizing retention of MDSO's in correctional facilities violated state and federal prohibitions against cruel and unusual punishment. The results of the present study showing relatively rapid release of such persons cast doubt upon the propriety of this decision and its basic assumption of nontreatment.

[12] Kozol, Boucher & Garofalo, *The Diagnosis and Treatment of Dangerousness,* 18 Crime & Delinquency 371, 378 (1972).

[13] *Id* at 392. *But see* Letter from Harry I. Kozol, Richard J. Boucher, and Ralph F. Garofalo to the Editor, 19 Crime & Delinquency 554 (1973) for the defense of this conclusion.

[14] Nat'l Advisory Comm'n on Criminal Justice Standards and Goals, Report on Corrections 156 (1973).

of Parole now relies heavily upon two relatively objective indices in making the parole release decision.[15] But, although there is some reason to believe that predictions of this sort may be more reliable than clinical predictions,[16] it is far from clear that these predictions meet acceptable standards. Cocozza and Steadman, for example, developed a sophisticated predictive device of this sort but nearly seventy per cent of their high risk group were false positives, *i.e.*, would not engage in the predicted aggressive behavior.[17]

Nevertheless, there is sufficient evidence of the unreliability of the sort of clinical predictions relied upon by the California MDSO program and many other aspects of the criminal justice and mental health systems to establish the need for further empirical research testing the accuracy of present predictive efforts and developing more accurate methods of prediction. Similarily, there is sufficient uncertainty concerning present ability to change behavior by treatment programs to require that empirical research address not only the identification of high risk offenders but also the impact upon recidivism of alternative methods of processing these persons. Most important is the development of information concerning the ability to predict and treat offenders, with all the practical problems it presents. This can only be done by testing the effectiveness of programs such as the MDSO program in actual operation. Followup studies are needed that permit comparison among different methods of predicting behavior and of attempting to reduce the danger posed by the high risk offender. The results need to be considered in light of cost of the alternative approaches, such as the duration and conditions of deprivation of liberty necessary to implement the programs, and as compared to how the offenders would otherwise have been processed. Only with this sort of comprehensive and comparative information can a reasonable evaluation be made concerning the acceptability of special programs for high risk offenders.[18]

[15] *See* Project, *Parole Release Decisionmaking and the Sentencing Process,* 84 YALE L.J. 810 (1975).

[16] *See* P. MEEHL, CLINICAL VERSUS STATISTICAL PREDICTION: A. THEORETICAL ANALYSIS AND A REVIEW OF THE EVIDENCE (1954).

[17] Cocozza & Steadman, *Some Refinements in the Measurement and Prediction of Dangerous Behavior,* 131 AM. J. PSYCHIATRY 1012 (1974).

[18] *Cf.* Dix, *"Civil" Commitment of the Mentally Ill and the Need for Data on the Prediction of Dangerousness,* 19 AM. BEHAVIORAL SCIENTIST 318 (1976).